



Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

APPLICATION PACKET

Client and Website Only

For questions please call:	
Regional Coordinator:	Manovna Narcisse
Counties Served by Region:	Orange
Phone: (407)858-1421	Confidential Fax: (407)845-6116
<p>Please use checklist below to ensure all paperwork is completed and returned with this coversheet to:</p> <p>Orange Regional FBCCEDP Office via confidential fax or mail to:</p> <p>Florida Department of Health Orange County Florida Breast and Cervical Cancer Early Detection Program</p> <p>6101 Lake Ellenor Dr Orlando, Florida 32809</p>	
CLIENT CHECKLIST	
<input type="checkbox"/>	Annual Applicant Agreement
<input type="checkbox"/>	Financial Eligibility Form
<input type="checkbox"/>	Client Enrollment Form
<input type="checkbox"/>	Initiation of Services <i>(for County Health Departments only)</i>
<input type="checkbox"/>	Authorization to Disclose Confidential Information
<input type="checkbox"/>	Your Provider's Mammogram Order



Orange

Florida Breast and Cervical Cancer Early Detection Program Client Enrollment Form

LAST NAME:	<input type="text"/>	FIRST NAME:	<input type="text"/>	MAIDEN NAME:	<input type="text"/>	DATE OF BIRTH:	<input type="text"/>
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1. APPLICANT INFORMATION (Please complete each section of this application.)

CONTACT INFORMATION		SCREENING STATUS (Check only one response.)	
STREET ADDRESS:	<input type="text"/>	<input type="checkbox"/> Initial (first time in program)	<input type="checkbox"/> Rescreen (previously in program)
STREET ADDRESS:	<input type="text"/>	<input type="checkbox"/> Short-term interval follow-up or repeat exam (less than 300 days from last screening)	
CITY & ZIP CODE:	<input type="text"/>	Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
EMAIL ADDRESS:	<input type="text"/>	If yes, what is the name of your insurance? <input type="text"/>	
PRIMARY PHONE:	<input type="text"/>	DEMOGRAPHIC INFORMATION	
ALTERNATE PHONE:	<input type="text"/>	RESIDENTIAL AND CITIZENSHIP STATUS (Check all that apply.)	
BEST TIME TO REACH YOU:		<input type="checkbox"/> Florida resident	<input type="checkbox"/> U.S. Citizen
<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.	<input type="checkbox"/> Citizen in lawful status	<input type="checkbox"/> Other
<input type="checkbox"/> Anytime		ETHNICITY AND RACE IDENTIFICATION (Check all that apply.)	
<input type="checkbox"/> Is it okay to leave a message?		<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/>
PREFERRED APPT. DAY/TIME <input type="text"/>		RACIAL IDENTITY	
HOW DID YOU HEAR ABOUT THIS PROGRAM? (Check all that apply.)		<input type="checkbox"/> American Indian or Alaska Native	
<input type="checkbox"/> American Cancer Society	<input type="checkbox"/> Postcard	<input type="checkbox"/> Asian	
<input type="checkbox"/> Brochure	<input type="checkbox"/> Television	<input type="checkbox"/> Black or African American	
<input type="checkbox"/> County Health Department	<input type="checkbox"/> Radio	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> Community/Health Fair event	<input type="checkbox"/> Social Media	<input type="checkbox"/> White	
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Educational Session	SPOKEN LANGUAGE(S)	
<input type="checkbox"/> Internet/Website	<input type="checkbox"/> Bus wraps/benches/signs	Primary language spoken:	<input type="text"/>
<input type="checkbox"/> Private Medical Office	<input type="checkbox"/> Billboards	Additional language(s) spoken:	<input type="text"/>
<input type="checkbox"/> Newspaper	Name of Community Health Clinic: <input type="text"/>	Language preference to receive mail:	<input type="checkbox"/> English
<input type="checkbox"/> Federally Qualified Health Center		<input type="checkbox"/> Spanish	
<input type="checkbox"/> Other		<input type="checkbox"/> Creole	

FOR OFFICE USE ONLY
Client Assigned ID# or Pseudo SS#: <input type="text"/>



Florida Breast and Cervical Cancer Early Detection Program Client Enrollment Form

LAST NAME:
 FIRST NAME:
 MAIDEN NAME:
 DATE OF BIRTH:

2. HEALTH HISTORY

GENERAL HEALTH STATUS (Check all that apply.)

Diabetes Pre-Diabetes
 High Blood Pressure High Cholesterol

HEIGHT (in.): WEIGHT (lbs.):

TOBACCO USE (includes vaping, e-cigarettes, and similar products) (Check all that apply.)

Daily Were you given a referral to Quitline?
 Some days Declined referral
 Never/not at all I am interested in quitting.
 Declined to answer

BREAST EXAM BACKGROUND (Check all that apply)

Do you have breast implants?
 Are you currently experiencing any issues with your breasts? Explain.

 Have you ever been diagnosed with breast cancer?
 If you have, what treatment did you receive?

 When did your treatment end (Month/Year)?

 When was your last mammogram before enrolling in this program? (Month/Year)
 None Unsure (5+ years)
 Where was your last mammogram done? (Provider, City, State)

CERVICAL EXAM BACKGROUND (Check all that apply)

Are you currently experiencing any issues with your cervix? Explain.

 Have you ever been told by a doctor you have invasive cervical cancer?
 If you have, what treatment did you receive?

 When did your treatment end (Month/Year)?

 When was your last Pap test before enrolling in this program? (Month/Year)
 None Unsure (5+ years)
 Where was your last Pap test done? (Provider, City, State)

 Have you ever had a hysterectomy? Specify whether partial or full.
 Partial hysterectomy (I still have a cervix) Full hysterectomy (no cervix)
 What was the reason for the hysterectomy?

FAMILY HISTORY

Has anyone in your family, such as your mother, sister, brother, or father, been diagnosed with breast cancer? If yes, which relative?

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#:



Orange

Florida Breast and Cervical Cancer Early Detection Program Clinician Report Form

1. CLIENT INFORMATION (Please complete each section of this form.)

LAST NAME: FIRST NAME: MIDDLE NAME: MAIDEN NAME:

DATE OF SERVICE (mm/dd/yyyy):

DATE OF BIRTH (mm/dd/yyyy):

HEIGHT (in.):

WEIGHT (lbs.):

MAMMOGRAM STATUS (For office use only)

INITIAL RESCREEN

SHORT-TERM FOLLOW-UP OR REPEAT EXAM

2. HEALTH HISTORY ASSESSMENT

PRESENT CONDITIONS (Check all that apply)

- Diabetes Client referred to services
- Pre-Diabetese
- High Cholesterol
- Hypertension

TOBACCO USE

(Includes vaping, e-cigarettes and similar products) (Check all that apply)

- Daily Referred to Quitline
- Some days No, not referred to Quitline
- Never/not at all Declined referral
- Declined to answer

BREAST HEALTH (Check all that apply)

Did client report any breast symptoms? (If so, describe below)

Client is high risk for breast cancer Risk not assessed

Clinical Breast Exam (CBE) completed

DIAGNOSTIC MAMMOGRAM (Check all required conditions that apply)

- Cystic or solid mass
- Bloody or serious nipple discharge
- Nipple or areola scaliness
- Skin dimpling or retraction
- Other suspicious findings (please specify):

NOTE: This section requires follow-up of two negatives.

SCREENING MAMMOGRAM

(Please check one CBE result for a screening mammogram)

- Normal/benign
- Nodularity
- Fibrocystic changes

CERVICAL HEALTH (Check all that apply)

(Note: FBCCEDP may cover Pap tests every 3-5 years unless previous Pap was abnormal.)

- Client is high risk for cervical cancer Risk not assessed
- PAP test performed
- HPV test performed
- Pelvic exam performed

If findings were abnormal, comment below.

CLINICIAN NAME:

SIGNATURE:

FOR OFFICE USE ONLY
Client Assigned ID# or Pseudo SS#:



Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

The Annual Applicant Agreement (AAA) is used to obtain authorization and information from eligible women enrolled in the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). The FBCCEDP will collect participant Protected Health Information (PHI) and Personally Identifiable Information (PII) that is required to provide patient services.

Please read each statement below and agree by signing at the bottom of the document.

As an FBCCEDP applicant, I declare that:

1. I am a Florida resident and I want to become a client of the FBCCEDP, and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level (FPL) and I have no health insurance that pays for breast and cervical cancer screening exams.
3. I will no longer be eligible for FBCCEDP if my income changes to above 200% of the FPL.
4. I will call FBCCEDP Once I obtain health insurance and give them the name of the health insurance company, policy number and effective date. If my health insurance covers breast and cervical cancer screenings my screenings will no longer be paid for by FBCCEDP.
5. I will disclose any breast or cervical screening services that may impact my eligibility of enrollment in FBCCEDP.
6. I may have a share of cost for some services.
7. I will use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test).
8. **I agree to complete any follow-up tests within 60 days. If I fail to meet these guidelines, I may be responsible for partial or full cost of all services.**
9. I will allow an exchange and release of my medical information between my health care providers, the FBCCEDP, the Florida Department of Health's Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination and procedure results, even if they were not paid by FBCCEDP.
10. I agree to receive home phone, cellphone, email or postal mail contact from FBCCEDP and the Department of Children and Families (DCF) Medicaid Program about my health care.
11. I understand that the FBCCEDP is a breast and cervical cancer **screening** program, not a cancer treatment program.
12. If I am diagnosed with breast or cervical cancer as a result of FBCCEDP screening, I will be referred to DCF Medicaid Program which will determine if I am eligible for Medicaid benefits to cover treatment cost. I can reapply to FBCCEDP for screenings once treatment is completed.
13. This agreement is for **one** year unless my program eligibility changes. If my eligibility status changes or this agreement expires, I may be responsible for services provided during my FBCCEDP ineligible period.
14. **As authorized by federal law, Title 5 U.S. Code section 552a, collection of social security numbers by the Florida Department of Health for the FBCCEDP may be necessary in order to apply for and receive Medicaid benefits.**

If you have any questions, contact your Regional Coordinator at the local Regional FBCCEDP office:

Local Regional FBCCEDP: Orange Phone #: 407-858-1421

Client Signature

Date

Printed Name

Date of Birth

Client Email Address: _____



INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client/Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature

Self or Representative's Relationship to Client

Date

Witness (optional)

Date

PART VII WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature Date

Witness (optional)

Date

Client Name: _____

ID#: _____

DOB: _____

Original to file; Copy to client



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ **Phone #:** _____

METHOD OF DISCLOSURE:

_____ **Pick up at Clinic/Facility**

_____ **Address:** _____

_____ **Fax #:** _____

_____ **Email Address: (please note that emailing may not be a secured method of communication)**

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ **General Medical Record(s)** _____ STD Records _____ TB Records _____ **History and Physical Results**

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ **Progress Notes**

_____ **Diagnostic Test Reports** (Specify Type of test(s)) _____

_____ **Other:** (specify) _____

I specifically authorize release of information relating to: (initial selection)

_____ HIV test results _____ Substance Abuse Service Provider Client Records

_____ Psychiatric, Psychological or Psychotherapeutic notes _____ **Early Intervention** _____ WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify) _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLASURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCAION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

Client/Legal Representative Signature

Date

Printed Name

Legal Representative's Relationship to Client

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).

Client Name: _____

ID#: _____

DOB: _____

Original: To File **Copy:** To Client **Copy:** To Accompany Disclosure



Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

FINANCIAL ELIGIBILITY

Client Name: _____ **Date of Birth:** _____ **ID#** _____

1. Do you have Medicaid? YES NO **OR** Do you have Medicare? YES NO
2. Do you have any form of health insurance? YES NO Name of insurance _____
3. **Number of people in your Household.** _____ (include yourself, spouse or civil union partner, and dependent children)
4. **Net Household Income (After Taxes):** \$ _____ Month **OR** \$ _____ Year

Family Size	2021 DOH Scale Monthly Income	2021 DOH Scale Yearly Income
1	\$2,146.58	\$25,759.00
2	\$2,903.25	\$34,839.00
3	\$3,659.91	\$43,919.00
4	\$4,416.58	\$52,999.00
5	\$5,173.25	\$62,079.00
6	\$5,929.91	\$71,159.00
7	\$6,686.58	\$80,239.00
8	\$7,443.25	\$89,319.00
9	\$8,199.91	\$98,399.00
10	\$8,956.58	\$107,479.00

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

NOTE:

If I obtain health insurance coverage, while under the FBCCEDP, it is my responsibility to notify the REGIONAL FBCCEDP office as soon as possible.

Signature _____

Date _____

If you have any questions Please call the regional coordinator at _____ between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.



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